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SOME OBSERVATIONS ON THE SURGICAL TREATMENT OF RECTAL AFFECTIONS.[1]

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THE frequent occurrence, pain, and discomfort of rectal diseases makes any contribution tending toward curing or alleviating them more speedily, thoroughly, or certainly, not wholly unwelcome. Several cases of rectal diseases which had been unsuccessfully operated on have lately come under my care, and as the writer has had some opportunities to compare the methods and results of the surgical treatment of these affections here and elsewhere, he has deemed it worth while to note the advance that has been made in this particular branch of surgery.

Said a well-known local surgeon in an amphitheatre before a class of students, "The operation for fistula is simple; any one can do it. Mr. —— can do it. Here, slit up this fistula," after he had introduced a director through the external and internal openings. The rapid placing of a pledget of lint and a T bandage made the performance seem simple enough. But this very patient, soon after leaving the hospital, returned with a recurrence of his malady, which had been superficially but not thoroughly operated on. So it was not soundly healed by so simple an operation as we were led to believe it would be.

Syme's [2] doctrine, that in performing the operation for anal fistula it is sufficient to divide the parts between the external and internal openings, regardless of farther-reaching sinuses, is not followed by beneficial results, except in a few persons of a strong, healthy

[1] Read at the meeting of the Cambridge Medical Improvement Society, May 23, 1881, and published in the Boston Medical and Surgical Journal, July 7, 1881.

[2] Diseases of the Rectum, third edition, page 43.

constitution. His theory, which has been entertained by some authors, that a fistulous sinus running up above the internal opening can be safely left untouched, is not borne out by experience. Failure of the operation thus performed is the result in the majority of cases. The inference to be drawn is obvious.

As a reward of an imperfectly-performed operation for anal fistula we have often seen a fresh sinus appear directly beneath the one operated on, and perhaps nearly cicatrized, or the wound not heal, owing to a branch or farther-reaching sinus which had not been properly laid open.

There is a distinction to be made whether a discharge comes from a healing, pus-secreting wound, or whether, coming from another source, it courses over a healing surface. In the latter case the discharge may catch under the healing edge of the wound, burrow, and finally form a sinus beneath the healing surface.

The old and unjustifiable process of excision of the tube-like fistulous track, as practiced now by an eminent professor of surgery in Paris, and also by a noted surgeon in this neighborhood, will often be followed by failure if a lateral branch sinus exists, which has to be cut across in the operation ; and this method cannot be commended, since it shows an ignorance of the pathology of anal fistula, and non-success is the usual result.

In a healthy subject an uncomplicated anal fistula occasionally heals spontaneously, or with the simplest treatment ; so it does sometimes by various caustics, injections, ligatures, elastic or otherwise, but the result by these means is always doubtful. In a complicated case, as frequently occurs, the free use of a cutting instrument is our main-stay, and we can never make sure of the result of a case unless we use it. To guarantee a cure the main and branch sinuses must be freely laid open, and the edges of the wound liberally trimmed off.

If severe hæmorrhage is apprehended after incising tracks reaching far up the bowel, the screw tourniquet

with twine, as Luke's, or, better, the elastic ligature, may be used for cutting through the cul-de-sac above the internal opening. The solid elastic ligature, with a metallic ring, is quicker in action, easily applied, and absolutely painless. The most successful prefer usually to cut, and depend on efficient plugging to arrest the hæmorrhage.

Beyond a thorough and solid packing of the wound with absorbent cotton (not lint as is used here), which serves greatly to consolidate the lax tissues, the wound requires but little active after-treatment, but jealous care and watching must be observed to detect early any small or perhaps unnoticed branch sinus.

The after-treatment is often delegated to a ward tender, a green medical officer, or may be to an inexperienced practitioner, and an unsuccessful result is sometimes due to this, much to the patient's disappointment and surgeon's chagrin.

Personal supervision for three or four weeks is necessary, then it may be entrusted to attendants, who are to notify the surgeon on the occurrence of any pain about the wound.

The discharge of pus in a case which has been properly operated on is insignificant in comparison with the often profuse and fetid discharge which comes from the branch sinuses of an incomplete operation. This is specially noticeable, and after a thorough operation, pus is remarkable by its absence, and also the wound soon becomes a healthy granulating ulcer. The fearful gash one sees after the proper operation on a complicated case of anal fistula reminds one of an amputation of the thigh. This is due to the thorough slitting up of all sinuses and crevices, the liberal trimming off of the edges, and the removal of the overhanging tabs, which swell (as the irritated gum does) and obstruct the free flow of the discharge. By so doing we have a shallow wound, all bottom and no top, and the rapidity with which these wounds heal under favorable conditions is surprising.

The solid packing of the wound in the first instance, compressing the vessels and thus arresting hæmorrhage, is allowed to remain to come away with the first motion of the bowels, which is to take place in three or four days. The curious treatment of removing the lint on the morning following the operation I consider wrong, deeming too much and constant dressing productive only of harm. If the flat wound gets flabby it may need the stimulating qualities of the usual remedies appropriate in such cases.

In the after-treatment it is usually sufficient to lay a light pledget of cotton on the wound, being on the look-out for new sinuses or crevices by running over the wound's surface with a probe.

If we would guarantee a cure, the operation must be properly done and subsequent treatment carefully attended to. In anal fistula dependent on stricture of the bowel, dilatation of the stricture must be done to insure a permanent cure.

The blind internal variety of anal fistula is not uncommon, and is readily detected by an experienced hand, and by attention to the patient's history.

It is to this class of fistula that I would especially call your attention, baffling, as it does, physicians, and most surgeons, yet giving great pain and discomfort to the patient if allowed to go unrelieved, such a case being classed as an obscure case. The remedy consists in making it a complete fistula, and operating as stated.

The futility of attempting to cure all cases of fistula ani by caustics, or injections, as by the charlatans, may well be taken to task by reference to cases of this variety. It is the happy result in these obscure cases which is gratifying to the surgeon.

We may attempt the use of an injection or caustic in a fistulous track, if great objection is made to other means, but it is not serviceable, takes a long time, may be a year or more, and in general is ineffectual, as in the cases so treated by the order of Louis XIV.

From the appearance of a fistula, experience very

often tells us, without questioning the patient, that he has some lung lesion, which, if in an active advancing stage, would influence us against performing any operation, other than for the mere relief of pain — nothing radical.

If the lung affection is stationary, a fair prospect of relief may be entertained by the elastic ligature, if the track is simple, or by the knife. Of course all these cases are not suitable for the latter means.

In all cases with rectal symptoms in which nothing pathological can be seen or felt to account satisfactorily for them, an enema should be administered, and bearing down of the lower bowel encouraged before an examination is made.

Such a procedure will often reward the surgeon by the detection of some lesion unattainable by other means, such as hæmorrhoids, prolapsus, certain tumors, etc.

The use of the anal speculum is limited, being used rarely by competent specialists in this department of surgery; in London they depend upon the information obtained by the "tactus eruditus" of a trained forefinger.

During a protracted service at St. Mark's (a hospital devoted specially to rectal diseases) I saw a rectal speculum used only once, and then at my request, so its employment is not as necessary an aid for a correct diagnosis as many imagine.

Through a simple incision the clot of blood in a case of external hæmorrhoids can be readily squeezed out, and oftentimes the severe, acute pain leaves as by magic.

In the operation for the cure of internal hæmorrhoids, the ligature, clamp and cautery, crushing, and acids have each their advocates.

Every case of piles does not mean surgical interference, but it should receive a proper examination to determine what method of treatment is suitable.

The use of nitric acid or the acid nitrate of mercury

or other caustics on the surface of a hæmorrhoid, even in the milder capillary form, is not be relied on; the relief is not sure nor permanent, especially if the patient leads an active life, and its employment is well-nigh discarded by those who were its warmest adherents. The injection, by a subcutaneous syringe, of an acid, like carbolic acid, or of a styptic, as solution of the persulphate of iron, into the substance of the pile, has been followed in mild cases by a shriveling up of the pile, but its use is not advised, as it is often painful, inefficient, and dangerous. Its use causes more inflammation than is desirable, a lengthy treatment with a doubtful result.

The recently advocated method of crushing, being about the same as the clamp without the cautery, does not promise any better results than are attainable by other and safer means.

The clamp and cautery, invented by Cusack, of Dublin, and improved by Mr. Henry Smith and others, has as great a reputation as facts warrant, and is suitable chiefly for slight cases. To hope for a good result the iron should be heated to a *dull red* heat, and applied over the *whole* cut surface so as to seal all the vessels completely.

The operation for prolapsus by the clamp and cautery is exactly the same as for hæmorrhoids, though it is generally supposed to be different.

Galvano puncture, producing interstitial cauterization, has been lauded by a few, but its use is not sure, is accompanied with great pain, inflammation, abscesses, and slow recovery.

The use of the ligature in the operation for hæmorrhoids in aggravated cases is the safest, surest, and best method for their obliteration, and has the most decided testimony in its favor for facility, efficiency, and safety. The advocates of the clamp and cautery attribute to the ligature greater liability to tetanus, pyæmia, and secondary hæmorrhage; but a well-known surgeon told me that in fifteen hundred cases of the

employment of the ligature he lost but one by pyæmia, and in his whole experience had seen but two die of tetanus, and then its appearance could be attributed to an extraneous cause. The liability to secondary hæmorrhage by the ligature is certainly less than after the separation of the escar after the cautery. Pyæmia, ulceration of the bowel, and fistulæ follow the use of the clamp and cautery quite as often as the ligature. The operation by the ligature, as done here, namely, transfixion with a double thread and tying each way, has always appeared to me a curious one, and one which does not have a true anatomical justification, and I think the pile is less thoroughly removed, and more likely to return than if Salmon's operation is employed. This consists in seizing the pile with a vulsellum, cutting from the white mark which is seen where the skin and mucous membrane meet with strong scissors parallel to the axis of the bowel, to a varying distance up the gut, then applying a single ligature which will be horizontal to the axis of the gut at the uppermost limit of the cut. By this means the larger vessels, which in the main come from above and supply the pile, are completely isolated. The vessels lie just beneath the mucous membrane, and are securely tied if the ligature is placed well at the bottom of the groove. If the operation is properly done return of the disease is rare, but it may return if the surface only of the pile is removed.

It certainly is a sensible operation, and has a sound anatomical justification from the disposition of the rectal vessels in the lower part of the bowel, and, moreover, there is less destruction of tissue than by other means.

Partial prolapse of the bowel, which is often connected with or mistaken for hæmorrhoids, may be cured by the ligature or the clamp and cautery, the operation being the same as for piles; but true prolapse in the adult, involving the whole calibre of the bowel, is best treated by the actual cautery at a dull

red heat. The number of the longitudinal scores on the prolapsed bowel should depend on its extent, but we should not omit to apply the hot iron in two or three places at the verge so as to get a contraction of that end of the bowel.

The treatment in cases of fissure does not consist solely of an incision through the sphincteric fibres, as suggested by Boyer, or through the mucous membrane, as maintained by Syme, or forcible dilatation of the sphincter ani, as suggested by Recamier, and later by Van Buren, but can very often be soundly and readily healed by appropriate medical treatment, — a laxative and an ointment.

Sometimes nothing short of an operation is effectual; this is specially the case when a polypoid growth hangs down from above into the fissure, as it not unfrequently does. The cases of fissure not ordinarily cured by the medical or surgical treatment stated are those in which this papilla-like body has been left, and its destruction is required before the fissure will heal soundly.

Some notes on the surgical treatment of the remaining rectal affections will be considered in a subsequent communication.